ENGLEWOOD
HOSPITAL AND MEDICAL CENTER

SCHOOL OF RADIOGRAPHY
APPLICATION FOR ADMISSION

NOTE: ALL PARTS OF THIS APPLICATION MUST BE FILLED IN COMPLETELY BEFORE CONSIDERATION FOR ADMISSION CAN BE MADE

DATE: _____

PLEASE PRINT

PERSONAL DATA			
NAME (Last)	(First)	(Middle)	PHONE
PRESENT ADDRESS			APT NUMBER
CITY		STATE	ZIP CODE

ARE YOU BELOW THE AGE OF 18? YES_____ NO_____ *IF YES,* INDICATE DATE OF BIRTH _____ MONTH _____ DAY _____ YEAR	EMAIL ADDRESS
SOCIAL SECURITY NUMBER - -	ARE YOU A UNITED STATES CITIZEN, NATIONAL, OR ALIEN? YES_____ NO_____
HAVE YOU EVER PREVIOUSLY FILED AN APPLICATION WITH US? YES_____ NO_____ *IF YES,* WHEN? _____	REFERRED BY EMPLOYEE_____ AGENCY_____ ONLINE_____ AD_____ OTHER_____ PLEASE SPECIFY: _____
HAVE YOU EVER WORKED AT ENGLEWOOD HOSPITAL & MEDICAL CENTER AS A: VOLUNTEER YES_____ NO_____ PAID EMPLOYEE YES_____ NO_____ *IF YES*, PLEASE SPECIFY: POSITION HELD: _____ DEPARTMENT: _____ DATES: FROM:_____ TO:_____	DO YOU HAVE ANY RELATIVES OR MEMBERS OF YOUR HOUSEHOLD WHO WORK AT ENGLEWOOD HOSPITAL & MEDICAL CENTER? YES_____ NO_____ *IF YES,* PLEASE SPECIFY: NAME: _____ DEPARTMENT: _____ RELATIONSHIP: _____

HAVE YOU EVER BEEN CONVICTED OF A CRIME OTHER THAN A MINOR TRAFFIC VIOLATION? YES_____ NO_____

IF YES, PLEASE EXPLAIN (INCLUDE DATES). THE CONVICTION OF A CRIME IS NOT AN AUTOMATIC BAR TO EMPLOYMENT. ALL FACTORS WILL BE CONSIDERED.

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COMPLETED APPLICATION SHOULD BE ACCOMPANIED BY THE FOLLOWING:

(1) HIGH SCHOOL DIPLOMA OR GED

(2) COLLEGE OR SECONDARY SCHOOL TRANSCRIPTS

(3) $50.00 APPLICATION/PROCESSING FEE

(4) COMPLETED AUTHORIZATION/RELEASE OF INFORMATION FORM

EMPLOYMENT HISTORY

PLEASE LIST BELOW, BEGINNING WITH YOUR MOST RECENT JOB, ALL PRESENT AND PAST EMPLOYMENT.

NOTE: IF YOU WERE EMPLOYED UNDER ANOTHER NAME, PLEASE INDICATE IT IN THE APPROPRIATE SPACE. IT WILL FACILITATE OUR REFERENCE CHECKING.

COMPANY	ADDRESS		
TYPE OF BUSINESS	CITY	STATE	ZIP CODE
NAME USED AS EMPLOYEE (IF DIFFERENT)	YOUR JOB TITLE		HOURS PER WEEK
DATES: FROM TO MM/YY / /	SUPERVISORS NAME	SUPERVISORS TITLE	SUPERVISORS PHONE
REASON FOR LEAVING (EXPLAIN)	BRIEFLY DESCRIBE TYPE OF WORK PERFORMED		
IF PRESENTLY EMPLOYED, HOW MUCH NOTICE OF RESIGNATION WOULD YOU BE REQUIRED TO GIVE? _____ WEEKS			

COMPANY	ADDRESS		
TYPE OF BUSINESS	CITY	STATE	ZIP CODE
NAME USED AS EMPLOYEE (IF DIFFERENT)	YOUR JOB TITLE		HOURS PER WEEK
DATES: FROM TO MM/YY / /	SUPERVISORS NAME	SUPERVISORS TITLE	SUPERVISORS PHONE
REASON FOR LEAVING (EXPLAIN)	BRIEFLY DESCRIBE TYPE OF WORK PERFORMED		

COMPANY	ADDRESS		
TYPE OF BUSINESS	CITY	STATE	ZIP CODE
NAME USED AS EMPLOYEE (IF DIFFERENT)	YOUR JOB TITLE		HOURS PER WEEK
DATES: FROM TO MM/YY / /	SUPERVISORS NAME	SUPERVISORS TITLE	SUPERVISORS PHONE
REASON FOR LEAVING (EXPLAIN)	BRIEFLY DESCRIBE TYPE OF WORK PERFORMED		

PLEASE LIST ANY OTHER POSITIONS HELD AND DATES OF EMPLOYMENT THAT ARE NOT LISTED ABOVE:

EDUCATIONAL BACKGROUND				
CIRCLE HIGHEST GRADE COMPLETED IN EACH CATEGORY:	*HIGH SCHOOL* 9 10 11 12	*COLLEGE* 1 2 3 4	*GRADUATE SCHOOL* 1 2 3 4	TOTAL COLLEGE CREDITS EARNED: _____

TYPE OF SCHOOL	NAME OF SCHOOL	ADDRESS	DEGREE (MAJOR)	DATES ATTENDED
HIGH SCHOOL/GED				FROM / TO /
COLLEGE (UNDERGRADUATE)				FROM / TO /
GRADUATE SCHOOL				FROM / TO /
OTHER EDUCATION/TRAINING				FROM / TO /

IN ORDER FOR CONSIDERATION OF ABOVE MENTIONED EDUCATION, OFFICIAL TRANSCRIPTS FOR EACH SCHOOL MUST BE RECEIVED. ALL CREDENTIALS ARE VERIFIED IN WRITING. IF YOU HAVE PREVIOUSLY WORKED/ATTENDED SCHOOL UNDER A DIFFERENT NAME, PLEASE SPECIFY NAME USED AND APPLICABLE DATES

AN EQUAL OPPORTUNITY INSTITUTION

IT IS THE POLICY OF ENGLEWOOD HOSPITAL AND MEDICAL CENTER THAT ALL STUDENTS AND APPLICANTS FOR ADMISSION ARE AFFORDED EQUAL OPPORTUNITY WITHOUT REGARD TO RACE, COLOR, NATIONAL ORIGIN, RELIGION, GENDER, AGE, DISABILITY, MARITAL STATUS, ATYPICAL HEREDITARY CELLULAR BLOOD TRAIT, DRAFT LIABILITY, AFFECTIONAL OR SEXUAL ORIENTATION.

PERSONAL STATEMENT

PLEASE EXPLAIN BRIEFLY WHY YOU ARE INTERESTED IN BECOMING A MEDICAL RADIOGRAPHER. THIS EXPLANATION SHOULD BE IN YOUR OWN HANDWRITING.

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ACCEPTANCE OF TERMS

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INDICATE YOUR UNDERSTANDING AND ACCEPTANCE BY SIGNING IN THE SPACE PROVIDED

1) I CERTIFY THAT ALL OF THE INFORMATION FURNISHED IN THIS APPLICATION AND ANY ADDITIONAL INFORMATION I FURNISH IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY MISLEADING OR FALSE STATEMENT OR ANY FAILURE TO ANSWER A QUESTION WILL RENDER THIS APPLICATION VOID AND WILL BE SUFFICIENT CAUSE FOR WITHDRAWAL OF AN OFFER OF ADMISSION OR IMMEDIATE DISMISSAL. I UNDERSTAND THAT ENGLEWOOD HOSPITAL AND MEDICAL CENTER WILL INVESTIGATE THE INFORMATION THAT I HAVE FURNISHED, AND I AUTHORIZE ANY PERSON, FIRM, OR ORGANIZATION TO SUPPLY ANY INFORMATION ABOUT ME CONCERNING MY PAST EMPLOYMENT, MILITARY SERVICE, EDUCATION, CONVICTIONS, OR OTHER INFORMATION TO ENGLEWOOD HOSPITAL AND MEDICAL CENTER. I RELEASE SUCH PERSON, FIRM, OR ORGANIZATION FROM ANY RESPONSIBILITY IN DISCLOSING SUCH INFORMATION. I AGREE TO CONFORM TO ALL RULES AND REGULATIONS OF THE HOSPITAL/SCHOOL.

2) I AGREE TO BE FINGERPRINTED AS A CONDITION OF ADMISSION.

3) ACCEPTANCE IS SUBJECT TO THE SATISFACTORY COMPLETION OF A PREADMISSION (POST-OFFER) PHYSICAL GIVEN BY EMPLOYEE HEALTH SERVICE AND UPON RECEIPT OF SATISFACTORY REFERENCES.

I AUTHORIZE ENGLEWOOD HOSPITAL AND MEDICAL CENTER TO VERIFY:

☐ ALL INFORMATION GIVEN

☐ ALL INFORMATION EXCEPT PRESENT EMPLOYER

SIGNATURE OF APPLICANT: _____ DATE: _____

REFERENCES

EACH APPLICANT IS REQUIRED TO SUBMIT THREE PROFESSIONAL AND/OR PERSONAL REFERENCES (NOT FROM FAMILY MEMBERS) ON ONE OF THE ENCLOSED FORMS. THE COMPLETED FORMS SHOULD BE RETURNED TO THE SCHOOL OF RADIOGRAPHY BY THE NAMED REFERENCES.

1)

NAME	ADDRESS	
OCCUPATION	CITY, STATE, & ZIP CODE	PHONE

2)

NAME	ADDRESS	
OCCUPATION	CITY, STATE, & ZIP CODE	PHONE

3)

NAME	ADDRESS	
OCCUPATION	CITY, STATE, & ZIP CODE	PHONE